

Within 30 days before the beginning of each fiscal year subsequent to the initial prospective year, each provider will be notified of their new prospective rate due to the normal operating rate adjustment. This rate shall apply to services provided on or after the beginning of the new fiscal year. Providers must split bill for services spanning the effective date of the rate change.

Providers will be notified of special rate adjustment no later than 45 days after the receipt of the appropriate data. Such rate change shall apply only to services provided on or after the forty-fifth day subsequent to the receipt of the adjustment data. Providers must split bill for services spanning the effective date of the rate change.

Subsequent years' adjustments for Medicaid disproportionate share, minimum occupancy (effective October 1, 1989 Tennessee Medicaid will not impose a minimum occupancy penalty), and resident and intern costs shall be completed at the same time and become effective at the same time as the pass-through adjustment.

Delays in setting rates may be encountered if it becomes necessary to request additional information from a provider due to errors or omissions on cost reports. Cost reports are due as specified by Medicare regulations in effect on October 1, 1982.

N. Automatic Adjustment for Medicare Adjustment - The following components of the prospective rate will be changed to reflect Medicare changes when announced by Medicare thru the Federal Registers or Federal law.

- (1) Operating component - will be indexed according to Prospective Payment Assessment Commission (PROPAC) recommendations.
- (2) Pass-thru component - will be adjusted for changes in Medicare reimbursement principles.
- (3) Indirect education - will be adjusted for Medicare index.
- (4) Operating component - will be rebased by Medicare announced PPS rebasing.

2. Method for Paying Providers Which Are Exempt From Prospective Payment Methodology - The per diem reimbursable costs for the Medicaid providers of inpatient hospital services exempted from the prospective methodology will be determined in accordance with Medicare principles of cost reimbursement in effect on October 1, 1982, and described in 42 CFR 405, except those hospitals described in Providers Exempted from Prospective Payment Methodology, which shall be reimbursed as described in that item. The maximum limit of such reimbursable costs shall be the lesser of: (a) the reasonable cost of covered services, (b) the customary charges to the general public for such services,

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or (c) the Medicaid reimbursement rate as established by the hospital's respective state. Covered services are those as defined by Tennessee Medicaid. Reimbursement by Tennessee Medicaid shall be considered as payment in full for covered services and no additional billings shall be made to the patient for these services.

In-state providers which are public hospitals rendering services free or at a nominal charge shall not be subject to the lower of cost or charges limitation but shall be paid fair compensation for services in accordance with the provisions of 42 CFR 405. Each provider's per diem reimbursable cost will be based on the provider's cost report.

- A. Interim Rate - An interim per diem reimbursable rate for these providers will be established. The interim rate remains in effect until the provider's actual reimbursable cost, based on the provider's cost report, is established. Interim rates shall be based on prior cost report data and shall be subject to revisions upon further review, audit and/or subsequent finding. For new facilities, budgeted information supplied by the provider may be used to establish an interim rate.
- B. Approval of Initial Settlement - When a provider's cost report is received, it is reviewed and compared with:
 - (1) The amount of charges for covered services provided to Medicaid beneficiaries by the provider during the provider's fiscal period.
 - (2) The amount of interim payments paid by the Department of Health to the provider for the provider's fiscal period.
 - (3) The number of inpatient days approved for the provider by the Department of Health during the provider's fiscal period.

On the basis of the comparison and review, an initial determination will be made of the cost settlement due to the provider or the State, for the designated period. Approval of the initial settlement will be subject to further review, audit and/or subsequent finding. On the basis of the initial settlement, the Department of Health will either make arrangements for an additional payment to the provider for services provided during the fiscal year or submit a claim to the provider requesting payment to the Department of Health for the amount of overpayment made to the provider during the fiscal year.

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- C. Approval of Final Cost Settlement. After the necessary final review and/or auditing has been performed by the Comptroller of the Treasury, the Comptroller will advise the Department of Health of the final cost settlement approved. On the basis of the approved final settlement, the Department of Health will either make arrangements for an additional payment to the provider for services provided during the fiscal year or submit a claim to the provider requesting payment to the Department of Health for the amount of overpayment made to the provider during the fiscal year.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES FOR INPATIENT HOSPITAL SERVICES

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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STATE TENNESSEEMETHODS AND STANDARDS FOR ESTABLISHING PAYMENT
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REIMBURSEMENT METHODOLOGY FOR PROVIDERS OF PSYCHIATRIC HOSPITAL SERVICES

Effective July 1, 1988, the single state agency shall reimburse inpatient psychiatric providers on a prospective basis for services provided under the State Plan.

All inpatient psychiatric hospitals, except those specified as exempt, with fiscal years beginning on or after July 1, 1988, shall be reimbursed on a prospective payment methodology. Exempt providers shall be reimbursed in accordance with Medicare, Title XVIII Principles and Standards in effect October 1, 1982, and described in 42 CFR 405. Exempt providers are subject to the revaluation of assets provision, Section 2314 of the Deficit Reduction Act (DEFRA).

Cost Reporting Requirement - In order to be eligible for payment by the Medicaid program for hospital services provided to Tennessee Medicaid beneficiaries, providers, including those paid by a prospective method, are required at each provider's fiscal year end, upon termination of provider status, change in ownership, or enrollment as a new provider, to submit to the Comptroller of the Treasury an annual cost report on forms designated by the Department. This report shall be submitted not later than three months from the end of each provider's fiscal year. Such cost reports must be completed in accordance with the Medicare principles of cost reimbursement set out in the Medicare Provider Reimbursement Manual, in effect on October 1, 1982, except where the Department may specify otherwise.

Providers that fail to submit cost reports which comply with Title XVIII principles in effect on October 1, 1982 and described at 42 CFR Part 405 shall be subject to penalties imposed by such regulations. Except as stated in item "C" of Providers Exempted from Prospective Payment Methodology, hospitals not filing cost reports for a specified period shall be required to refund all payments made under this program for that period.

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Any contracting provider that does not adopt the uniform classification of accounts, or other acceptable accounting methods as shall be established by the Department of Health and Environment in consultation with the Comptroller and the Tennessee Hospital Association, or does not submit cost data as required by the Department of Health and Environment, shall be assessed a penalty of ten dollars (\$10.00) for each day such provider is not in compliance.

Records Retention - Each hospital provider is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than five years from the date of the submission of the cost report, and the provider is required to make such records available upon demand to representatives of the State Department of Health and Environment or the United States Department of Health and Human Services. All cost reports shall be retained by the State Comptroller of the Treasury for a period of not less than five years from the date of submission of the cost report.

Audit Requirements - All hospital cost reports are subject to audit at any time by the Comptroller of the Treasury and the Medicaid Agency or their designated representative. Cost report data must be based on and traceable to the provider's financial and statistical records and must be adequate, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. Retroactive adjustments to the prospective rate may be made for audit exceptions. Hospitals will be subject to medical audits at any time. Medical audits include, but are not limited to, "medical necessity" or "length of stay". Medical audit exceptions may result in a direct recoupment rather than a rate change.

Providers Exempted from Prospective Payment Methodology - The prospective payment system shall not apply to the following hospitals and services:

- A. Any health care facility that is not a hospital, skilled nursing facilities and intermediate care facilities located within hospitals when certified or licensed as "nursing" homes and swing beds, while being used to provide nursing services at less than the acute level of hospital care.

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- B. Inpatient services provided before July 1, 1988, by providers of either inpatient psychiatric services to persons under the age of twenty-one (21), or inpatient hospital services in institutions for mental disease to individuals age sixty-five (65) or older.
- C. Psychiatric hospitals which elect not to submit a cost report and which have less than \$10,000 annually, based on the provider's fiscal year, in total charges to patients determined eligible for Medicaid by the State of Tennessee. Such providers shall be reimbursed an amount not to exceed 80% of reasonable charges for covered items billed by the provider. Reasonable charges are those which are charged by comparable providers for similar services. In the event that providers exceed \$10,000 in total Tennessee Medicaid charges annually, they will be treated as new providers.
- D. Outpatient hospital services, as defined by the October 1, 1986, edition of 42 CFR 440.20.
1. Prospective Payment Methodology
- A. Except as provided by other provisions of this State Plan amendment, each hospital's reimbursable inpatient costs will be determined in accordance with Medicare Title XVIII principles from a base year cost reporting period. Costs will be separated into an operating component and a pass-through component. A trending factor will be applied to the operating component only. The prospective rate will consist of the trended operating component. Tennessee Medicaid costs will be determined by a computed utilization ratio from HCFA Form 2552 which must be submitted by the provider. The prospective payment (operating costs) will be made as a rate per inpatient day. On and after July 1, 1988, in psychiatric hospitals and institutions for mental disease, which dates apply without regard to the date upon which the provider's fiscal year may end, the pass-through component will not be a part of the per diem rate, but will, instead, be paid in lump sum amounts on a monthly basis.
- B. Pass Through Component
- (1) For inpatient services in psychiatric facilities on or after July 1, 1988, irrespective of provider fiscal year end, the

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reimbursable per diem rate will consist of only the operating component. The remaining components: capital, direct medical education, and return on equity will be paid in a lump sum amount. Capital, direct medical education, and return on equity costs will be estimated from each provider's most recent cost report on file as of 4:30 p.m. C.D.T., Monday, June 30, 1988. The estimate will be used to compute a lump sum amount for capital, direct medical education, and return on equity. Payment will be made monthly starting July 1, 1988. Each provider's subsequent cost report will be used to adjust the capital, direct medical education, and return on equity for the subsequent fiscal year. This adjustment shall be effective on the first day of the next month, one month subsequent to the date of receipt of the provider's cost report. Capital, direct medical education, and return on equity costs will be subject to year end cost settlement for inpatient psychiatric services on and after July 1, 1988.

- 2(a) Effective October 1, 1991 and later, capital related costs will be reduced by 15% for dates of service October 1, 1991 and later. Reduction will be figured into year end final settlements. Hospitals designated as Sole Community Hospitals are exempt from percentage reductions in capital related costs.
- 2(b) Additional costs due to revalued assets will be recognized only when an existing provider is purchased by another provider in a bona fide sale (arms length transaction). The new value for reimbursement purposes shall be the lesser of (1) the purchase price of the asset at the time of the sale, (2) the fair market value of the asset at the time of the sale (as determined by an MAI appraisal), (3) current reproduction cost of the asset depreciated on a straight line basis over its useful life to the time of the sale, or (4) for facilities undergoing a change of ownership on or after July 18, 1984, the acquisition cost to the first owner of record on or after July 18, 1984. The purchaser has the burden of proving that the transaction is a bona fide sale should the issue arise. Gains realized from the disposal of depreciable assets while a provider is participating in the program are to be a deduction from allowable capital costs. All sales as of July 18, 1984, will be in compliance with the provisions of Section 2314 of DEFRA.

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- (3) The payment of return on equity will be determined by Medicare principles of cost reimbursement, 42 CFR 405, in effect on August 1, 1983 providing that, effective April 20, 1983, return on equity shall be adjusted to reflect 100% of the average rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.
- (a) The return on equity for acute care and psychiatric proprietary providers will be reduced as follows: for cost reporting periods beginning after September 1986, payment will be 75% of the current amount; 50% of the current amount for reporting periods beginning after September 1987; 25% of the current amount for reporting periods beginning after September 1988; and zero thereafter.
- C. Operating Component - Each facility's initial prospective rate shall also include an operating component which is based on the base year cost report. In base years all providers including providers that are within the first three years of operation will be subject to the routine per diem cost limitation for prospective rate purposes. The routine per diem limitations for these purposes will be set in the same manner as those used for acute care hospitals. All new providers may have their prospective rate adjusted at the end of the first five year period. The operating component will be trended forward each year. The trending period shall be from the midpoint of each hospital's base year to the midpoint of the hospital's first cost reporting period subject to prospective payment. Except for trending to the new rebased year (1988 cost reports or if not available the prior cost report) which will be the indexing rate recommended by the Prospective Payment Assessment Commission, the trending index which shall be applied to the operating component shall be as follows:

<u>Period Covered</u>	<u>Rate</u>
10/1/85-9/30/86	0%
10/1/86-9/30/87	1.15%
10/1/87-6/30/88	2.7%
7/1/88-6/30/89	0%

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Thereafter, the trending index shall be that rate of increase on prospective payments as recommended by the Prospective Payment Assessment Commission and is published in the Tennessee Administrative Register. The trending indexes above shall be applied from the midpoint of each provider's fiscal year, to the midpoint of the subsequent fiscal year. When necessary, indexes will be prorated to correspond to the provider's year end. Each provider will be notified of their new operating rate due to indexing within 30 days of the beginning of each fiscal year.

Medical malpractice insurance reimbursement will be limited to 7.5% of allowable malpractice insurance premiums for prospective rate purposes.

- D. Minimum Occupancy Adjustment - Capital costs shall be adjusted each year, using the formula set out below, if a facility's occupancy rate, based on staffed beds during the year, is below a minimum level. If a hospital exceeds its minimum occupancy rate, the formula is not applied. The minimum level is as follows:

Hospitals over 100 beds - 70%

Hospitals with 100 beds or fewer - 60%

The adjustment will be computed as follows and will be made at the same time as the pass through adjustment.

$$ACC = TCC \times \frac{TBD}{ABD (Y)}$$

ACC = allowable capital costs

TCC = total capital costs

TBD = total bed days used during the period

ABD = total bed days available during the period

Y = .6 for hospitals with 100 beds or fewer

= .7 for hospitals over 100 beds

All references to beds mean staffed beds. Staffed beds mean those beds which are equipped and available for patient use. Any beds or hospital wing which is unavailable for patient use, such as being closed for reasons including but not limited to, painting,

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